No. 93-120

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Under applicable Medicare regulations, hospitals that furnish services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable cost," including direct and indirect costs, of certain education programs for health professional trainees, including residents. The programs for the training of residents are referred to as graduate medical education or GME programs. The Secretary denied the Hospital reimbursement for the actual reasonable costs of operating its GME programs using a novel interpretation of regulations in force for over 20 years. The question presented for review is:

Whether the Secretary's denial of Petitioner's claim for the reasonable costs of its GME programs on the ground that the claim constituted an impermissible redistribution, and on the ground that the community had undertaken to support those programs, is arbitrary, capricious, an abuse of discretion and not in accordance with law.

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OPINIONS BELOW

The United States Court of Appeals for the Third Circuit issued a judgment, but no opinion. The judgment (Pet. App. 1a-2a) is not reported. The opinion of the United States District Court for the Eastern District of Pennsylvania (Pet. App. 3a-25a) is not reported.

There are two administrative decisions concerning this case. The Provider Reimbursement Review Board ("PRRB") is the administrative tribunal with jurisdiction to hear and review Medicare reimbursement disputes. Its decision in this matter, PRRB Dec. No. 90-D5 (Pet. App. 38a-60a), is reported in [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,276 (Nov. 17, 1989). The Administrator of the Health Care Financ-

ing Administration ("HCFA") is the agent of the Secretary of the Department of Health and Human Services (the "Secretary") with authority to review PRRB administrative determinations. Decisions of the Administrator constitute final agency action. The Administrator's decision (Pet. App. 28a-37a) is reported in [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990).

JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on April 21, 1993. Pet. App. 2a. The petition for a writ of certiorari was filed on July 20, 1993, and was granted on January 10, 1994. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provision, 42 U.S.C. § 1395x(v)(1)(A), is reprinted at Pet. App. 61a-62a. The relevant regulatory provision, 42 C.F.R. § 413.85, is reprinted at J.A. 40-41.

STATEMENT OF THE CASE

Thomas Jefferson University Hospital (the "Hospital") is a 700-bed teaching hospital (Pet. App. 8a),[1] and a participating provider in the Medicare program. Pet. App. 5a. The Hospital is owned and operated by Thomas Jefferson University ("University"), a private, not-for-profit educational institution which also owns and operates the Jefferson Medical College (the "Medical School") and other entities. Pet. App. 8a. Thomas Jefferson University was founded in 1824. *Id.* The Hospital was opened in 1877, and has been in continuous operation since

[1] Items from the record in this case are cited to the Appendix to the Petition for a Writ of Certiorari ("Pet. App. __"), the Joint Appendix ("J.A. __"), or the Administrative Record, which was filed in the district court below ("A.R. __").

then. *Id.* The Hospital is an approved Medicare provider (Pet. App. 5a), and has participated in the program since its inception in 1966. Pet. App. 8a. This case involves a dispute over the proper amount of Medicare reimbursement due the Hospital for its fiscal year ended June 30, 1985.

A. The Medicare Program

Title XVIII of the Social Security Act established the federally-funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. § 1395 *et seq.* Under the hospital insurance provisions of the Medicare Act, payments are not made to individual beneficiaries; instead, the Medicare program reimburses participating hospitals ("providers") for the costs of treating eligible beneficiaries.

Determination of the amount of Medicare reimbursement to which a provider is entitled is a multi-step process. A provider first files a cost report with its "fiscal intermediary" (typically an insurance company which, pursuant to contract with the Secretary, provides payment to providers). This cost report is the basis for the calculation of the provider's Medicare reimbursement. 42 C.F.R. §§ 413.20(b), 413.24(f). Upon receipt of a provider's cost report, the fiscal intermediary analyzes the reported data, undertakes any necessary audits, and informs the provider, through a written Notice of Program Reimbursement, of the amount of Medicare reimbursement to which the provider is entitled. 42 C.F.R. § 405.1803. If the provider is not satisfied with this determination, and the total amount in controversy is at least $10,000, the provider may request a hearing before the PRRB. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. The PRRB serves as a tribunal within the Department charged with exclusive jurisdiction over Medicare cost reimbursement claims. The members of the PRRB are required by statute to be knowledgeable in the field of Medicare cost reimbursement and at least one of them must be a certified public accountant. 42 U.S.C. § 1395oo(h).

For fiscal years beginning on or after October 1, 1983, providers are reimbursed for the costs associated with the provision of inpatient hospital services to Medicare beneficiaries pursuant to a prospective payment system. 42 U.S.C. § 1395ww(d). However, certain categories of costs incurred by providers, including medical education costs, are exempt from prospective payment. 42 U.S.C. § 1395ww(a)(4). For the cost year at issue, a provider's approved medical education costs were reimbursed on a retrospective, reasonable cost basis. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.85.[2]

Reasonable costs are to be determined in accordance with methods adopted by the Secretary. Congress specifically directed, however, that such methods must not result in other purchasers of a hospital's services bearing any of the costs of treating Medicare patients, nor in Medicare bearing any of the costs of treating non-Medicare patients. 42 U.S.C. § 1395x(v)(1)(A). This prohibition against cross subsidization has always been a feature of the Medicare program, and is the standard by which the Secretary's determinations with regard to reimbursable costs must be judged. *See Loyola University of Chicago v. Bowen*, 905 F.2d 1061, 1073 (7th Cir. 1990); *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1212 (6th Cir. 1989).

The Medicare statute defines "reasonable costs" broadly:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . .

[2] From the inception of the Medicare program in 1966 through fiscal years beginning before July 1, 1985, graduate medical education costs were reimbursed on a retrospective, reasonable cost basis. Congress changed the method of reimbursing GME costs, effective for fiscal years starting after June 30, 1985, to one which is based on a provider's average cost per GME resident in a past year. 42 U.S.C. § 1395ww(h).

42 U.S.C. § 1395x(v)(1)(A). The Secretary's regulations define reasonable costs as the "direct and indirect costs of providers of services" and include "all necessary and proper costs incurred in furnishing the services." 42 C.F.R. § 413.9(a), (b)(1). The term "necessary and proper costs" is similarly defined broadly to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." 42 C.F.R. § 413.9(b)(2).

B. Medicare Reimbursement Of Graduate Medical Education Costs

Reasonable costs include a provider's costs associated with approved GME activities. The regulations at 42 C.F.R. § 413.85 are the governing regulations for the reimbursement of costs associated with educational activities.[3] Section 413.85(a) provides that "a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section." Section 413.85(b) defines approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution," and requires that such programs be licensed or receive approval from a recognized national professional organization. 42 C.F.R. § 413.85(b). Subsection (c), which was relied on below to support the Secretary's refusal to reimburse Petitioner for its full graduate medical education costs, provides:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appro-

[3] The relevant paragraphs of 42 C.F.R. § 413.85 are set forth in full at J.A. 40-41.

> priately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

42 C.F.R. § 413.85(c). Finally, as relevant here, subsection (g) defines the reasonable costs of operating GME programs as:

> Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.85(g).

Medicare regulations allow a hospital to claim the costs incurred by a medical school in connection with the operation of the hospital's GME programs, when the hospital and the medical school are related by common ownership or control.

> [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

42 C.F.R. § 413.17(a) (Pet. App. 63a).

The Secretary herself has interpreted this regulation as permitting a provider to claim patient care costs incurred by a

related medical school. For example, in guidelines issued to private entities who administer the Medicare program (intermediaries), the Secretary identified certain costs incurred by related medical schools which could be included in a provider's GME costs, including costs of teaching faculty salaries, a medical library, physician office space and clerical support. *See* Intermediary Letter 78-7 ("IL 78-7") (Pet. App. 64a-65a). These costs normally would be incurred directly by a hospital that operated GME programs independently of a related medical school. *Id.*

There is no dispute that Congress recognized the value of GME programs in enhancing the quality of patient care in health care institutions. Until the community at large undertakes the responsibility to pay the costs associated with GME programs, Congress directed that "part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by [Medicare]." S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977 (J.A. 32). *See also* H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965) (J.A. 31-32). The Secretary's regulation now found at 42 C.F.R. § 413.85 is "widely accepted" as reflecting this express Congressional intent that the Medicare program share in the cost of GME programs. Pet. App. 14a-15a. The regulation also reflects Congress' understanding that GME programs contribute to the quality of patient care for Medicare and non-Medicare patients.

The relevant statutory provisions and regulations at issue here have been part of the Medicare Act and regulatory scheme since the program's inception.[4] Despite this fact, the Secretary

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[4] The regulation which is now designated 42 C.F.R. § 413.85 was first published in the Federal Register on November 22, 1966, 31 Fed. Reg. 14808, 14814 (J.A. 34). Originally, the regulation was designated 20 C.F.R. § 405.421. It was redesignated 42 C.F.R. § 405.421 on September 30, 1977

did not begin to treat claims for reimbursement of related-party medical school costs as raising any issues regarding "redistribution" until the mid-1980s. Moreover, although section 413.85(c) has always been a part of the Medicare regulatory scheme, the Secretary concedes that no criteria have ever existed for determining when community support exists. J.A. 51. The Secretary never formally defined "redistribution" until she issued her proposed modifications to section 413.85(c) in September 1992. J.A. 55.

In the absence of any formal definition, the only meaning to be ascribed to the "community support" and "redistribution" concepts comes from the relevant legislative history, the Secretary's own previous interpretations and practices, and the plain meaning of the regulation, read in context with the entire statutory and regulatory scheme. These sources demonstrate that the interpretation of the regulation adopted by the Secretary here is not supported by the legislative history, and is directly contrary to the Secretary's own previous interpretations of the regulation. Moreover, the Secretary's current interpretation is contrary to the plain meaning of the regulation.

C. The Hospital's 1985 Claim For GME Costs

The Hospital is the approved operator of GME programs in various specialties and subspecialties. Pet. App. 39a. In 1985, the Hospital's GME programs involved 320 full-time equivalent residents. *Id.* There is no dispute that the Hospital's GME programs contribute to the quality of patient care in the Hospital. Pet. App. 17a. Although the Hospital has participated

(42 Fed. Reg. 52886), and as 42 C.F.R. § 413.85 on September 30, 1986 (51 Fed. Reg. 34790). On September 29, 1989, the Secretary promulgated a new regulation, 42 C.F.R. § 413.86, to implement a new payment methodology for the clinical education of interns and residents. *See* 54 Fed. Reg. 40286 (Sept. 29, 1989) (J.A. 42). On September 22, 1992, the Secretary proposed certain modifications to 42 C.F.R. § 413.85. *See* 57 Fed. Reg. 43659-73 (Sept. 22, 1992) (J.A. 45). The Preamble to that proposed regulation contains a discussion of the history of the GME regulation. J.A. 47-51.

in the Medicare program since 1966, it did not begin claiming related-party GME costs (that is, costs incurred by the Medical School) until 1974. Pet. App. 8a. When it initially claimed GME costs in 1974, those costs were paid by the program. *See* Pet. App. 32a. The Secretary did not assert in 1974, or thereafter, that the Hospital's failure to claim GME costs from 1966-73 was "presumptive" evidence that the community had been supporting the Hospital's GME programs. *Id.*; Pet. App. 58a. Nor did the Secretary refuse the Hospital's claim on the ground that it constituted a "redistribution."

Although the Hospital and the Medical School are separate administrative units, they are unincorporated divisions of a single entity, the University. A.R. 132. As such, they are "related parties" under applicable Medicare regulations. 42 C.F.R. § 413.17(a). The University produces an audited financial statement which combines the operations of each of its administrative units (Hospital, Medical School, College of Allied Health Sciences, and College of Graduate Studies). A.R. 131. The Hospital and the Medical School have separate budgets, and the University's policy is that those budgets be balanced. A.R. 132. In 1985, however, the Medical School operated at a deficit. *Id.*

The University is a private institution. It receives limited state support in the form of appropriations from the Commonwealth of Pennsylvania and the State of Delaware. Pet. App. 60a. Both of these appropriations, however, are specifically limited to use for undergraduate medical education. *Id.* Thus, the University receives no public funding whatsoever for its graduate medical education programs.[5] The other Medical

[5] Even though state appropriations have increased each year, the *percentage* of the Medical School's costs which is funded by state appropriations has been steadily decreasing. In 1972-73, the appropriation from Pennsylvania made up 35 percent of the medical school's operating costs. Pet. App. 60a. Between 1973 and 1984 state appropriations increased 24 percent, but in 1984, the state appropriation constituted just 16 percent of the Medical

School sources of funding include undergraduate tuition (which increased 360 percent between 1973 and 1983) (A.R. 142), funds the Hospital transfers to the Medical School for services rendered to the hospital, gifts and grants, and practice plan revenues (physician charges to patients). A.R. 819.

The Hospital's 320 full-time-equivalent residents provide services to Hospital patients under the supervision of Medical School faculty. GME training activities traditionally occur in hospitals because such activities involve little academic or classroom activity, but rather consist almost entirely of learning through the provision of care to patients, much of which can occur only in a hospital. A.R. 133-34. To operate a GME program, a hospital must either hire faculty and support staff itself or arrange for them to be provided by a medical school. Here, the Hospital relies on the related Medical School to provide the services needed to operate the Hospital's GME programs. Thus, although the Hospital is the licensed operator of the University-approved GME programs, for internal administrative purposes, the Medical School has been delegated the responsibility for administering them. *Id.* The Medical School selects and evaluates the residents; its faculty and their clerical support staff are responsible for assigning, training and supervising the residents; and Medical School facilities are used for carrying out the administrative aspects of these responsibilities. *Id.* The Hospital does not duplicate these activities and their related costs, but instead uses the Medical School's resources as its own. A.R. 135.

Medical School faculty who are full-time are paid by the University for their teaching, administrative and research duties.

School's operating costs of $27,202,000. *Id.*; A.R. 142. During the same period, the Medical School's operating costs increased by 164 percent. A.R. 928.

[6] In 1984, the Hospital claimed and the intermediary allowed additional categories of costs related to its GME programs. *See* Pet. App. 35a n.10.

Historically, the compensation of most full-time faculty is charged to Medical School accounts. A.R. 136. Compensation for some faculty, however, such as those involved in the administration of hospital-based departments (*e.g.*, radiology, pathology), is charged directly to Hospital accounts. A.R. 136. No faculty physicians are compensated by the University for their direct patient care services to individuals. A.R. 183. Faculty physicians bill and are compensated separately for their patient care services through the full-time faculty practice plans. A.R. 183.

For a number of years, the Hospital has reimbursed the Medical School for GME teaching efforts in two ways. First, it has paid directly the salaries of some hospital-based faculty. Second, it has transferred additional money to the Medical School for a portion of faculty salaries attributable to GME teaching efforts, specifically the supervision of residents and interns. Pet. App. 9a. Payments related to faculty teaching efforts were charged to a Hospital account called "professional salaries." *Id.* The amount of the transfer by the Hospital to the Medical School above the direct salaries paid by the Hospital was determined by analyzing "Personal Activity Reports" completed by physicians every six months. *Id.* On these forms, faculty members were asked to account for their time in categories such as research, instruction, sponsored programs, administration and hospital activity. A.R. 139. Based on these reports, the Hospital reimbursed the Medical School for a portion of faculty salaries related to GME activities. Pet. App. 9a.

Prior to 1985, the amount of the claims for related-party costs associated with the GME programs had always been

When the inconsistency in its treatment of the Hospital's claim for additional GME costs between 1984 and 1985 was pointed out, the intermediary conveniently characterized its action in 1984 as a "mistake." *Id.*

[7] Based on the 1985 cost study, the Hospital claimed $6,614,724 in GME costs. Pet. App. 10a. The amount of costs allowed, including amounts

allowed by the intermediary. Pet. App. 40a.[6] Although the system for determining the extent of costs attributable to GME teaching efforts originally was designed to be as accurate as possible, beginning in 1984 and continuing in its 1985 cost year, the Hospital undertook to refine its cost-finding techniques to ensure that all of the costs properly attributable to the operation of GME programs were identified and claimed for reimbursement. Pet. App. 9a. Thus, in 1985, the Hospital engaged a national accounting firm to conduct a cost study to identify all costs related to its ongoing GME programs. *Id.*

The 1985 cost study identified an additional $1,979,091 in Medical School costs attributable to the Hospital's GME programs beyond the costs which had been allowed.[7] If these costs are fully allowed, as Petitioner asserts they should be, the cost to the Medicare program will be approximately $600,000.[8] The portion of the Medical School's total costs for which Medicare reimbursement is sought is quite small. In fiscal year 1985, the Medical School's total costs were nearly $30,000,000. A.R. 819. Moreover, the cost study proves that the costs for which reimbursement is sought were actually incurred in support of the Hospital's GME programs. Pet. App. 57a. Thus, the Secretary's attempt below to raise the specter of wholesale cost shifting from medical schools to hospitals (*see* Pet. App. 34a-35a) is not supported by the record in this case.

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allowed pursuant to a settlement agreement between the Secretary and the Hospital at the district court (*see* J.A. 2), was $4,635,633. Thus, the remaining amount in dispute is $1,979,091.

[8] The Medicare program shares in a provider's allowable costs to the extent Medicare beneficiaries use the provider. *See* 42 C.F.R. § 413.50. In the cost year at issue, approximately 35 percent of the Hospital's allowable costs were paid by Medicare, based on Medicare patients' usage of the Hospital. A.R. 133.

The Hospital's 1985 request for GME program reimbursement was denied by the fiscal intermediary, which claimed that the costs were an impermissible "redistribution." Pet. App. 10a. The Hospital appealed the intermediary's decision to the PRRB. Pet. App. 11a. The PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented in the cost study. Pet. App. 38a-60a. The PRRB agreed with the Hospital that the cost study complied with the full costing requirements of 42 C.F.R. §§ 413.24 and 413.85(g) by identifying the total allowable costs incurred by the Medical School in support of the Hospital's GME activities, including direct and indirect costs. Accordingly, the PRRB found that the intermediary's disallowances were improper and that the Hospital should be permitted to claim the full amount of GME costs documented by the cost study. Pet. App. 56a.

The PRRB specifically rejected the intermediary's argument that the cost study resulted in a "redistribution" of costs from the Medical School to the Hospital.

> [H]istorically, the Provider has always utilized the services of faculty members of its related Medical School for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed. . . . In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to its ongoing educational activities. The fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention.

Pet. App. 58a-59a.

Upon review, the Secretary, acting through her agent, the Administrator of HCFA, reversed the PRRB. Pet. App. 28a-37a. The Administrator reasoned that since these costs had not been claimed by the Hospital in earlier cost years, they presumptively constituted a "redistribution" of costs previously borne by the "community" (the Medical School) to the Hospital. Pet. App. 35a.[9] In effect, the Secretary has created an irrebuttable presumption that costs of a related-party medical school not previously claimed by a hospital were borne by the community and any later claim for those costs is an impermissible redistribution.

Here, the sources of funding which the Secretary believed constituted "community support" for the Hospital's GME programs included the tuition charged to undergraduate medical students, hospital fees (*i.e.*, charges to sick patients), grants, bequests, and state-funded support for undergraduate medical

[9] The Administrator also concluded that some of the incremental costs claimed by the Provider would not have been allowable even if redistribution were not an issue because they were beyond the scope of costs allowable pursuant to IL 78-7. Pet. App. 37a. The Secretary also raised this issue in the litigation regarding Ohio State University's similar claim for reimbursement. *See Ohio State University v. Sullivan*, 777 F. Supp. 582, 588-89 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993). The Secretary has abandoned that claim here. According to the Secretary's statement of the question presented to this Court, the issue is: "Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of *otherwise reimbursable* GME program costs that previously were absorbed by its affiliated medical school." *See* Brief for the Respondent on Petition for Writ of Certiorari, *Thomas Jefferson University v. Shalala*, No. 93-120, at (I) (emphasis added). In other words, if the community support and redistribution principles of section 413.85(c) do not bar the Hospital's claim, the Secretary concedes that they are "otherwise reimbursable." *See also* Secretary's Petition for Writ of Certiorari, *Shalala v. Ohio State University*, No. 93-696, at 6 n.5 (dated November 1993) ("The court also rejected the Administrator's determination that the indirect GME-related costs were not allowable costs under the Medicare Act. . . . That ruling is not at issue here.").

education programs from Pennsylvania and Delaware. Pet. App. 32a. Petitioner asserts that as a matter of fact and a matter of law, none of these sources can appropriately be considered "community support" for GME. Moreover, the Secretary determined that the Hospital's claim constituted a "redistribution" by focusing on only the last clause of the last sentence of the relevant regulation. Her inappropriate fixation on the term "costs" in that sentence led her to ignore totally the part of the sentence which comes before, and which provides that the Medicare program will share in the GME costs of *activities* customarily and traditionally carried on by providers.

The Hospital timely appealed the Secretary's determination to the United States District Court for the Eastern District of Pennsylvania. There, on cross motions for summary judgment, the court determined that the Secretary's interpretation of the community support and redistribution principles of section 413.85(c) were reasonable and entitled to deference. Pet. App. 23a-24a. The Hospital timely appealed the district court's decision to the Third Circuit, which, on April 21, 1993, entered a judgment, with no opinion, affirming the district court. Pet. App. 1a-2a.

SUMMARY OF ARGUMENT

At issue in this case is whether the Hospital is entitled to reimbursement from the Medicare program for certain graduate medical education costs which are related to patient care and incurred by a related medical school. The Medicare statute directs that providers of Medicare services are to be reimbursed for all costs found to be "reasonable" and "necessary" in the delivery of needed health services to Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). The Secretary does not dispute that the costs at issue here were reasonable and necessary in the delivery of needed health services to Medicare beneficiaries. On the contrary, the Secretary concedes in this Court that, but

for her application of section 413.85(c) to this claim, the costs at issue are reimbursable. *See* n.9, *supra*.

Section 413.85(c) provides:

> Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

42 C.F.R. § 413.85(c).

The Secretary reached her conclusion that the Hospital was "redistributing" costs from an educational unit to a patient care unit in violation of the regulation, by focusing narrowly on whether the Medical School or the Hospital had historically borne the *costs* of GME programs. The Secretary's reading of the regulation focuses exclusively on the last clause of the last sentence of the section, ignoring the regulation's statement of intent to share in the costs of GME *activities* of the type traditionally carried on by providers. Petitioner asserts that the

Secretary's interpretation of the regulation in this case is contrary to its plain meaning, is inconsistent with nearly 20 years of agency practice, and results in absurd reimbursement decisions, which violate the statute's requirement that Medicare pay its fair share of costs of treating Medicare beneficiaries.

In addition, the Secretary's attempt to create an irrebuttable presumption of "community support" from the fact that costs previously were not claimed has no basis in the record, and is contrary to Congressional intent. The Secretary's presumption results in the absurd conclusion that whether a hospital is entitled to be reimbursed for related-party medical school costs depends not on whether there is any evidence of actual community support for the hospital's GME programs, but rather on the fortuity of whether the hospital has previously claimed such costs. Moreover, the Secretary maintained below that "community support" is any source of funding for medical education *other than* the Medicare program. Pet. App. 18a. Such an interpretation is clearly contrary to Congress' expressed intent at the time the Medicare Act was passed. Finally, the specific types of funding the Secretary pointed to in this case as evidence of community support plainly are not the sort of "public and private contributions" intended for the support of graduate medical education programs that Congress contemplated when it referred in the legislative history of the Medicare Act to the "ideal" of community support.

ARGUMENT

I. STANDARD OF REVIEW

On appeal under the Administrative Procedure Act, 5 U.S.C. § 706, this Court must review the administrative record anew and decide all relevant questions of law, interpret constitutional and statutory provisions, and hold unlawful any administrative decision that is arbitrary, capricious, an abuse of

discretion, unsupported by substantial evidence, or otherwise not in accordance with law.

In reviewing agency actions under the arbitrary and capricious standard, the Court must consider "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). An agency action is arbitrary and capricious if the agency has "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Similarly, the substantial evidence standard requires an in-depth review of the facts relied upon by the agency in its decision. At a minimum, a decision is not supported by substantial evidence unless the record contains such relevant evidence that a reasonable mind might accept as adequate to support the challenged conclusion. *Airport Shuttle Serv., Inc. v. Interstate Commerce Comm'n*, 676 F.2d 836, 840 (D.C. Cir. 1982).

Although an administrative agency's interpretation of its own regulations is generally entitled to deference, an agency's interpretation is not shielded "from a thorough, probing, in-depth review." *Citizens to Preserve Overton Park*, 401 U.S. at 415. *See also Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977). As this Court has explained, the existence of prior inconsistent interpretations detracts substantially from the deference normally due an agency's interpretation of its own statute and regulations. *See General Elec. Co. v. Gilbert*, 429 U.S. 125, 141-43 (1976). As the Court recently noted:

> [T]he consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "an agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."

Good Samaritan Hosp. v. Shalala, 124 L. Ed. 2d 368, 382 (1993) (quoting *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (emphasis added)). *See also Bowen v. American Hosp. Ass'n*, 476 U.S. 610, 646 n.34 (1986) (agency interpretation which has neither been consistent nor longstanding substantially diminishes any deference due).[10] Moreover, "an agency changing its course . . . is obligated to supply a reasoned analysis for the change. . . ." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 42.

II. THE SECRETARY'S INTERPRETATION OF SECTION 413.85(c) IS ARBITRARY, CAPRICIOUS AND UNSUPPORTED BY SUBSTANTIAL EVIDENCE

The Secretary denied the Hospital's claim on the ground that the reimbursement sought constituted redistribution of *costs* from the Medical School to the Hospital. According to the Secretary, since the Hospital had not previously claimed some of the Medical School costs it now claims as GME costs, its reimbursement claim and any similar claim in the future constitutes a prohibited "redistribution." In effect, the Secretary created an irrebuttable presumption that it was a redistribution for the Hospital to claim costs it had not previously claimed. Pet.

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[10] *See also United Transp. Union v. Lewis*, 711 F.2d 233, 242 (D.C. Cir. 1983) ("A statutory construction to which an agency has not consistently adhered is owed no deference."); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 718 F.2d 459, 464 (D.C. Cir. 1983); *Northwest Hosp., Inc. v. Hospital Serv. Corp.*, 687 F.2d 985, 991 (7th Cir. 1982); *Saint James Hosp. v. Heckler*, 760 F.2d 1460, 1472 (7th Cir.), *cert. denied*, 474 U.S. 902 (1985) ("Although an agency is not rigidly bound to its own precedent, the presumption is against changes in established policy that are not justified by the rulemaking record.").

App. 34a-35a.[11] According to the Secretary, this result is mandated by the portion of section 413.85(c) which provides that:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary interprets section 413.85(c) to mean that the *costs* at issue must have been "customarily and traditionally" claimed by a hospital.

A. The Secretary's Interpretation Of The Regulation Is Inconsistent With Its Plain Meaning

The Secretary's interpretation violates the plain meaning of her own regulatory framework. As a reading of the regulation makes clear, and as the courts in *Ohio State University* found, the prohibition against redistribution is contained in a sentence that begins, "the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers. . . ." 42 C.F.R. § 413.85(c) (emphasis added). The clear meaning of this passage is "to allow providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations." *See Ohio State University*, 777 F. Supp. at 587.

Teaching hospitals, such as Petitioner, customarily and traditionally engage in the clinical training of interns and residents in a hospital setting. Indeed, the Hospital has operated

[11] *See also Ohio State University*, 777 F. Supp. at 588 ("The Administrator seems to have concluded that since these costs had not been claimed in prior years, there was an irrebuttable presumption that they represented a redistribution of costs of the medical school to the Provider").

GME programs since well before the inception of the Medicare program. Pet. App. 8a. Educational institutions, on the other hand, customarily and traditionally engage in classroom training, undergraduate medical education, and other non-clinical education activities. As the district court in the *Ohio State University* case recognized:

> In the case of graduate medical education, it would be customary and traditional for a teaching hospital to employ qualified physicians in various medical specialties to select and supervise the interns and residents enrolled in the educational program. These physicians would need clerical and administrative staff, office space and supplies to carry out their function. Their salaries, the salaries of their clerical and administrative staffs, and the cost of their office space and supplies would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care in the hospital. . . . They would be the kind of costs Congress intended that the Medicare program should participate in.

Ohio State University, 777 F. Supp. at 587.

B. The Secretary's Interpretation Is Inconsistent With Her Internal Policies And Previous Application Of The Regulation

That the *Ohio State University* court properly interpreted section 413.85(c) is evidenced by the Secretary's own actions, both with respect to her past treatment of the Hospital and her past and current interpretations of the redistribution language. For example, the Hospital filed its first claim for reimbursement of related-party GME costs in 1974. If the Secretary's current interpretation of section 413.85(c) is correct, of course, that claim was a "redistribution," since, at that time, the Hospital had not "historically" claimed such costs. The Secretary did not deny the Hospital's claim in 1974, nor, prior to the mid-1980s,

did she ever claim that any teaching hospital claiming GME costs for the first time, or simply claiming *increased* costs, was engaged in a "redistribution."

The Secretary's 1974 treatment of Petitioner's request for reimbursement of related-party GME costs was no mere fluke. Indeed, the Secretary's internal operating guidelines issued to provide guidance to teaching hospitals for claiming costs incurred by a related medical school recognizes as "allowable *hospital* costs" the reasonable costs incurred by a related medical school in support of the hospital's GME programs. IL 78-7 (Pet. App. 64a). Nowhere does IL 78-7 suggest that these cost claims must meet the Secretary's redistribution analysis. Nor does IL 78-7 suggest that teaching hospitals can claim as related-party medical school costs only those costs which they have historically claimed. By the time IL 78-7 was issued, the Medicare program had been operating for more than 10 years. If the Secretary's current interpretation of the regulation is correct, IL 78-7 should have instructed intermediaries that any related-party GME costs not previously claimed represented a prohibited redistribution. It did not. It is remarkable that neither the concept of redistribution nor the relevant regulatory section is cited in the Secretary's internal guidelines for the proper treatment of GME costs by teaching hospitals. This absence is persuasive evidence that the Secretary's interpretation of section 413.85(c) is *not* a long-standing or consistent policy, but rather a recently-discovered tool for denying legitimate reimbursement claims.

This conclusion is also supported by the Secretary's past treatment of similarly-situated hospitals. For example, the record demonstrates that between at least 1982 and 1986, HCFA was engaged in correspondence related to the University of Oregon's Health Sciences University's ("Oregon") request for reimbursement of related-party medical school costs incurred in support of the hospital's GME programs. J.A. 22-30. It is clear

that in 1982, those costs had not previously been claimed by the University. In a 1982 memorandum, the HCFA Regional Office requested guidance from the Director of the Office of Reimbursement Policy regarding Oregon's request. J.A. 22-24. The Regional Office noted that there was ambiguity between the redistribution concept expressed in the Provider Reimbursement Manual and IL 78-7 which makes no mention of redistribution. *See* J.A. 23. HCFA responded that "allocation of costs to a hospital from a related medical school is governed by Intermediary Letter 78-7." J.A. 25. The HCFA response did not suggest that GME costs raised any question regarding an impermissible "redistribution," despite the Regional Office's express reference to the redistribution concept. Certainly, the response does not suggest that the hospital's failure to claim these costs prior to 1982 makes the request a "presumptive" redistribution. *See* J.A. 25-26.

In a 1985 memorandum, HCFA disingenuously attempted to "clarify" the 1982 memorandum. J.A. 27 ("The fact that [redistribution] is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 C.F.R. [413.85(c)]."). The failure of the 1982 memorandum to mention redistribution in the context of a specific request for a clarification of the applicability of the redistribution concept in light of IL 78-7, could hardly be characterized as an oversight. Rather, it is powerful proof the agency did not consider a first-time request for reimbursement of related-party GME costs to constitute a redistribution. Moreover, if redistribution had been the agency's policy in 1982, all the advice HCFA supplied with respect to Oregon perfecting its cost claim would have been purely academic. Apparently the 1985 memorandum was later repudiated. Subsequent correspondence from the author of the 1985 memorandum to Oregon discusses the general allowability of related-party medical school costs in a hospital's costs for GME programs again without mentioning either the concept of redistribution or the specific regulation. J.A. 29-30. In any

event, it is clear that the "policy" set forth in the 1985 memorandum was never applied to disallow related-party GME costs claimed *for the first time* by Oregon in 1982-83.[12]

C. The Secretary's Application Of The Redistribution Principle Here Is Inconsistent With Her Recent Treatment Of The Concept In Proposed Regulations

The Secretary's treatment of this Hospital and similarly-situated hospitals is rife with inconsistencies. Aside from these informal memoranda and letters, the best source for the Secretary's actual interpretation and application of the redistribution concept is in the GME regulation itself and the preamble discussions to various modifications of it.

For example, in the Preamble to the 1989 GME Regulation, 54 Fed. Reg. 40286, 40302 (J.A. 43), the Secretary responded to an inquiry about the proposed regulations requesting clarification regarding the "treatment of GME costs of a related medical school," and, specifically, "whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical

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[12] *See University Hospital & Clinic (Portland, Ore.) v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Oregon*, PRRB Hearing Dec. No. 93-D56, [1993-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,605 (July 15, 1993). This case involved the ability of the University of Oregon to be reimbursed for the full amount of faculty physician teaching and administrative costs for fiscal years 1978 through 1981. Prior to fiscal year 1978, the university hospital did not claim Medicare reimbursement for services rendered at the hospital by the medical school's clinical faculty physicians. The PRRB disallowed the costs at issue for fiscal years 1978-1981 based on an application of Medicare's reopening rules, rather than on the redistribution prohibition. In his dissenting opinion, PRRB member Roark stated that the costs of faculty teaching and administrative services had been allowed for fiscal years 1982 and 1983. *Id.* at p. 36,744. Thus, it is evident that the directive in HCFA's correspondence dated December 1985 (J.A. 28) was never implemented or applied to these fiscal years.

school." *Id.* In response, the Secretary stated that "[c]ertain identifiable activities *conducted by the faculty of a related medical school*, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes." *Id.* (emphasis added). The Secretary explained, for example, that costs incurred by a university medical school for office space and clinical support to physicians supervising interns and residents in a hospital's GME program "*may be allowable if it can be demonstrated* to the satisfaction of the fiscal intermediary that such costs are *directly related to the training program of the interns and residents working in the university hospital* and are related to the care and treatment of the hospital's patients." J.A. 44. (emphasis added). In the preamble, the Secretary also specifically authorized hospitals to present information regarding any factors they believe should be taken into consideration in determining their allowable base period GME costs and "to introduce additional GME costs not previously claimed" in connection with the reaudit activity under the amended GME regulations. J.A. 42. The failure of the Secretary, when squarely faced with the issue, to articulate a policy of redistribution in connection with a related-party GME clinical training costs claim, cannot be dismissed as mere inadvertence. Rather, it is clear evidence that she had no such policy.

Finally, in the preamble to proposed regulations relating to nursing education and allied health, 57 Fed. Reg. 43659 (Sept. 22, 1992) (J.A. 45-52]), the Secretary states categorically that the redistribution principle is inapplicable to graduate medical education costs incurred by a related-medical school as provided in IL 78-7:

> The current regulation concerning related organizations at § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than arm's length bargaining.

> This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (*with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78-7*), our policy has been that the provider, rather than the related organization, must directly incur the costs on its books and records before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result in a redistribution of costs from the educational institution to the provider would be violated.

J.A. 53-54 (emphasis added). This, of course, is precisely the point argued by the Hospital: that the redistribution principle has *never* been applied to GME clinical training costs for which reimbursement is permitted pursuant to IL 78-7.

Obviously, the Secretary's interpretation of her regulation in this case does not represent "long-standing" policy. Rather, the interpretation appears to be newly arrived at, and adopted for the purpose of denying legitimate claims in order to save the program money. Although the Secretary presumably is entitled to consider the costs of her actions, she cannot change a long-standing interpretation of a regulation, without notice or comment, and with no specific Congressional authorization, solely to save the program money. *See Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086, 1094 (9th Cir. 1983). Such action is contrary to the specific statutory direction that hospitals be reimbursed on the basis of their reasonable costs and the requirement that the Secretary's reasonable cost calculation methods shall not result in shifting costs of treating Medicare patients to non-Medicare patients. 42 U.S.C. § 1395x(v)(1)(A).

The Secretary's focus on whether costs have customarily and traditionally been claimed violates the plain meaning of the

regulation and her past practices. Moreover, even assuming that the "customarily or traditionally" test applies to costs as well as activities, what is a customary or traditional cost? Is it a dollar amount; if so, why aren't reasonable and necessary increases reimbursable?[13] Is it a period of time; if so, what number of years of not claiming the cost is sufficient to disqualify all future reimbursement and what number of years of claiming a cost is sufficient to permit future claims for increases in reimbursement?[14] Is it a "type" of expense and, if so, are "types" of expense fixed in perpetuity? As of which year? Is it historical cost accounting, no matter how flawed, out-of-date, or inappropriate? If so, does that permit the Secretary to close her eyes to more current cost studies, which demonstrate that adjustments or refinements to existing cost allocations are more proper, sensitive, and accurate? The Secretary's steadfast refusal to look at the *actual* evidence of the Hospital's true GME costs in favor of a presumption based on historical cost claims is the very essence of arbitrary and capricious agency action. Moreover, the change in her interpretation of the redistribution regulation, with no explanation for the change in policy, is arbitrary and capricious.

The policy of the Medicare Act is clear. Congress sought to provide a system of medical insurance for the aged and disabled. The system designed directs that providers of medical services are to be reimbursed for their reasonable costs of furnishing needed health services to covered beneficiaries. The Secretary's decision here, affirmed by the courts below, that certain costs cannot be reimbursed because they were not

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[13] As noted above, the Medical School's costs increased dramatically between 1974 and 1984. *See* n.5, *supra*.

[14] Recall, it is undisputed that reimbursement was claimed by the Hospital for Medical School costs and allowed by Medicare for the first time in 1974. Pet. App. 8a.

claimed from the inception of the Medicare program, is flatly inconsistent with the basic purpose of the statute.

III. THE SECRETARY'S APPLICATION OF THE "COMMUNITY SUPPORT" LANGUAGE TO DENY THE HOSPITAL'S CLAIM IS ARBITRARY AND CAPRICIOUS

The district court found that "the Secretary views community support as any source of funding other than the Medicare program." Pet. App. 18a. Moreover, the court noted that "[t]he Secretary's decision in this case considered community support to include 'tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware.'" *Id.* The court found this definition reasonable and "entitled to deference." *Id.* The court's determination was based on its conclusion that the Secretary's definition was "consistent with both the American Hospital Association ("AHA") principles as well as the Secretary's earlier applications of the community support principle in the context of disputed claims for reimbursement of GME program costs." *Id.*[15] Significantly, the court never considered whether the Secretary's definition of "community support" was consistent with Congressional intent. Clearly, it is not.

[15] Although the district court found that the Secretary's interpretation of the community support issue was "consistent" with other cases, the only example cited was *University of Minnesota Hospitals & Clinics v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Minnesota*, [1992-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,420, at 26,828 (May 29, 1991). Pet. App. 18a. This case is from the same time period as Thomas Jefferson's request. Prior to about 1985, it does not appear that the Secretary had ever denied a claim for GME costs either on the basis that the costs had been "redistributed" from a related medical school to a hospital, or on the ground that the costs had previously been borne by the community.

A. The Secretary's Definition Of "Community Support" Is Inconsistent With Congressional Intent And Previous Agency Policy

The Secretary's current interpretation — that community support is every non-Medicare source of funding — simply makes no sense when examined in the context of the time the statute was written, when all medical education programs were 100 percent supported by non-Medicare funds. It is one thing to find that an agency is entitled to make reasonable interpretations of a statute where the statute is ambiguous or incomplete. *Chevron United States, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). It is quite another, however, to allow the Secretary to adopt an interpretation of language which it is simply impossible for Congress to have intended. Such "deference" goes too far.

Moreover, the Secretary's definition is *not* consistent with AHA principles,[16] with the Secretary's earlier application of the

[16] The Secretary relied on the AHA's Cost Reimbursement Guidelines and testimony of an AHA representative at the hearing on the original Medicare Act (J.A. 31) to develop her GME cost reimbursement regulation. *See* Pet. App. 18a; J.A. 47. The AHA Guidelines provide:

> Section 2.302 — In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion. . . .
>
> COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility.

J.A. 33.

principle in regard to *this* Hospital, or with her treatment of similarly-situated hospitals. First, the AHA Guidelines as they existed at the start of the Medicare program recognized that charges to sick patients did not constitute community support, and clearly recognized that GME programs were *not* receiving community support. J.A. 33. Thus, not all sources of funding for GME programs then in existence (all of which were non-Medicare) constituted "community support." *Id.* Second, the Secretary's treatment of the Hospital's previous claims demonstrates that her interpretation is not consistent. If the Secretary's current interpretation is correct, the GME costs which the Hospital began to claim in 1974 were borne by the "community" — since they were financed by sources other than Medicare. That the Secretary did not disallow the Hospital's increased GME cost claims in 1974 demonstrates that her current interpretation is not "consistent" with past practice.

This conclusion is further supported by the recent rulemaking activity in this area. In 1992, the Secretary promulgated proposed regulations to amend section 413.85(c). *See* 57 Fed. Reg. 43659 (J.A. 45). In her proposed regulations, the Secretary admits that no criteria previously existed for determining whether there has been "community support" for GME programs. *See* J.A. 51. Her proposed regulation does indeed purport to establish prospectively "community support" from failure to claim a cost in the past. However, if no criteria previously existed, and there was no notice of the Secretary's definition of community support, the Secretary's claim that the Hospital, in effect, voluntarily waived in perpetuity its right to reimbursement for the reasonable costs of its GME programs because it failed to claim those costs at the onset of the Medicare program is arbitrary and capricious.

B. The Secretary's Interpretation Of "Community Support" Is Inconsistent With Her Own Regulations

1. The Secretary Attempts to Give the Language of Subsection (c) Meaning Not Evident on its Face

The Secretary's interpretation of "community support" within the meaning of section 413.85(c) is also inconsistent with the other sections of that regulation. Subsection (c) of the Secretary's regulation stands out from the other subsections of the regulation, and from the Secretary's other Medicare regulations, in that the language used is general, explanatory, almost philosophical. In sharp contrast, the other subsections of section 413.85, as well as the Secretary's other Medicare reimbursement regulations, consist of technical directions or definitions which describe how the Medicare program is to be implemented. In general, the Secretary's cost reimbursement regulations are filled with details regarding the specific types of costs, the methods for measuring costs, and cost accounting principles for allocating overhead costs and apportioning costs to Medicare patients. *See, e.g.*, 42 C.F.R. § 413.94 (value of services of non-paid workers); 42 C.F.R. § 413.134 (determination of depreciation); 42 C.F.R. § 413.53 (overhead allocations); and 42 C.F.R. § 413.50 (apportionment of costs).

Indeed, the other subsections of section 413.85 proceed in this manner. Subsection (a) directs that a provider's costs may include its net cost of approved educational activities. It cross references other regulations and other subsections for further instructions on the calculation of "costs" and "net costs." Subsection (b) defines "approved educational activities" in precise terms, and mandates that such programs must either be licensed or recognized by national professional associations.

Subsection (c), in contrast, starts out with a general policy statement on Medicare support of medical education programs

conducted by hospitals, the first two-thirds of which is taken practically verbatim from the legislative history of the Act. *Compare* 42 C.F.R. § 413.85(c) *with* H.R. Rep. No. 213 (J.A. 31-32), *and* S. Rep. No. 404 (J.A. 32). Rather than providing instructions or definitions, this section repeats Congress' expressions of approval for medical education generally, and its precatory "ideal" of "community support" of such educational activities, which is also articulated in the legislative history. *Id.* Certainly the regulation does not instruct a provider on what community support is, how it is to be measured, or the impact on increased costs of medical education programs relative to levels of community support. Nor does the regulation, on its face, alert a provider to the draconian results of a failure to claim from Medicare the full reasonable costs of GME programs which are the outcome of the Secretary's application of her new interpretation of subsection (c) to this Hospital.

Subsection (g) defines the term "net costs" of approved education programs. These are the costs that the Medicare program will share in. If "community support" were to be factored into the determination of the amount of GME costs Medicare would share in, one would expect to find the subject addressed here. The subject is not addressed. Rather, net costs are defined simply as full costs less tuition. 42 C.F.R. § 413.85(g).

Here, the Secretary identified "tuition, hospital fees, grants, bequests and state funded support from Pennsylvania and Delaware" as the sources of "community support" for the Hospital's GME programs. Pet. App. 32a. Two of these sources — tuition and the state appropriations — clearly support only undergraduate education. Pet. App. 48a. They cannot be deemed support for the Hospital's GME programs. One of the items — hospital fees (*i.e.*, charges to sick patients) — was specifically singled out in the legislative history as *not* constituting community support. *See* J.A. 31, 33. And the final two items — grants and

bequests — are not required to be offset against allowable costs by the Secretary's own regulations, as discussed below.

2. The History of the Definition of "Net Costs" Demonstrates There is No Basis for the Secretary's Current Reading of Community Support

The history of the definition of "net costs" supports Petitioner's argument that the sources of funding identified by the Secretary in her decision below as evidence of "community support" for the Hospital's GME programs do not constitute community support either on the record in this case or under the Secretary's own regulations.

Originally, net costs were calculated by offsetting from full costs "grants, tuition and specific donations." 20 C.F.R. § 405.421(b)(2) (J.A. 34). In 1980, the regulation was amended to preclude the offset of certain specific grants and donations for primary care internships and residency programs. 45 Fed. Reg. 51783, 51786 (Aug. 5, 1980) (J.A. 38-39). Finally, in 1984, the Secretary's regulations were revised to disregard *all* gifts and grants in determining allowable education costs. 49 Fed. Reg. 234, 296 (Jan. 3, 1984) (J.A. 40-41). This revision was designed to make the Secretary's regulation for calculating net costs for purposes of GME reimbursement consistent with her regulations regarding calculating net costs under other Medicare reimbursement regulations. *See Id.*

In explaining why she was exempting gifts and grants from items to be offset against total costs, the Secretary said:

> Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating Sec. 405.423 [which re-

> quired the offset of restricted grants, gifts and income from endowments]. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

48 Fed. Reg. 39752, 39797 (Sept. 1, 1983). If "community support" in the GME regulation had the meaning the Secretary now ascribes to it, however, these funds should logically be offset against total cost for purposes of determining allowable GME costs.[17] Yet, the Secretary revised her regulation to eliminate the offset of these costs for purposes of calculating total allowable GME costs. J.A. 39-40. Having eliminated those items from the category of funds which must be deducted from full costs to determine allowable GME costs in subsection (g), the Secretary in effect attempts to read them back into the regulation under the vague "community support" language of subsection (c). Such slight-of-hand rulemaking is arbitrary and capricious. The Secretary cannot change her regulation regarding the treatment of these types of funds by reference to a vague policy that has never previously been defined, with no explanation for the change and without notice or an opportunity to comment on the change.

Finally, the district court found justification for the Secretary's interpretation of "community support" in another Congressional policy — that reflected by the 1983 Amendments to the Social Security Act. According to the district court, interpreting the regulation to allow the Hospital's claim would "plainly conflict" with the purpose of the 1983 revisions, which

[17] Apparently recognizing this inconsistency, the Secretary is considering revising her net cost definition again, to reinstate the offset for "donations, grants and *non-Medicare* public funding from the provider's total allowable costs. . . ." J.A. 54 (emphasis added). The fact remains, however, that during the Hospital's 1985 cost year, grants, donations and other non-Medicare funds were *not* required to be offset from total costs to determine allowable costs.

was to "stem[] the spiraling costs of the Medicare program. . . ." Pet. App. 20a. *See also* Brief for the Respondent on Petition for a Writ of Certiorari, at 6. The 1983 change in Medicare reimbursement cited by the Court did not give the Secretary *carte blanche* to ignore the reasonable cost standards of 42 U.S.C. § 1395x(v)(1)(A) in her reimbursement decisions. On the contrary, the reasonable costs provisions in the Act and regulations as applied to GME programs were not repealed by the 1983 Amendments, and continued to apply in full force to the costs of those programs. There is no principle of statutory or regulatory construction which would allow the Secretary to use one policy change to justify changing a previous interpretation of a regulation and policy that was in the Act before and that specifically was *excluded* by Congress from the change in policy.[18]

In short, there is nothing in the record to support the Secretary's claim that this Hospital was receiving "community support" for its graduate medical education programs. Moreover, the district court's finding that the Secretary's interpretation of this regulation comports with the regulation's "plain meaning" and is entitled to deference because of her long-standing application of the regulation is wrong. The "plain meaning" of community support, as evidenced by the Secretary's past actions in this area, does not support her current interpretation. Finally, the Secretary's interpretation of the regulation has been anything but consistent.

[18] In 1986, Congress did mandate a prospective change to the way Medicare would participate in the costs of GME programs. 42 U.S.C. § 1395ww(h). *See* n.2, *supra*. Congress' revisions to the program arguably reflect a policy determination to try to control the costs of graduate medical education programs. That Congress saw fit to take such action, on a prospective basis in 1986, suggests that its 1983 Amendments do *not* give the Secretary the authority to try to limit Medicare participation in GME costs.

IV. THE DECISION BELOW INTERPRETS SECTION 413.85(c) IN A MANNER INCONSISTENT WITH THE MEDICARE STATUTE

In promulgating the Medicare Act in 1965, Congress made clear its intent that Medicare providers were to be reimbursed, as nearly as possible, for all costs necessarily incurred in the efficient delivery of health care services to Medicare beneficiaries. The Senate Report accompanying the Medicare Act states Congress' explicit intent:

> Although [reimbursement] may be made on various bases, the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program.

S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976. This expression of Congressional purpose is codified in the Act where the Secretary is directed to issue regulations for determining reasonable costs under the Medicare program. 42 U.S.C. § 1395x(v)(1)(A). There, Congress directed that the Secretary's regulations

> *shall* . . . take into account both direct and indirect costs . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].

Id. (emphasis added).

The result of the Third Circuit's judgment affirming the district court decision here is exactly contrary to Congressional intent: it shifts the costs of providing services to Medicare beneficiaries to individuals not covered by the program. The Secretary's interpretation of the redistribution language was found to result in just this sort of impermissible cost-shifting in *Ohio State University*, 777 F. Supp. at 587 ("If the Medicare program did not pay its fair share of [GME program] costs, there is a likelihood that they would be shifted to non-Medicare patients in violation of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A). . . ."). The effect of the Secretary's interpretation of the community support language is the same. For whatever fiction she may concoct from the fact that a hospital has not previously claimed GME costs, the fact remains that absent actual community support and reimbursement of its fair share by Medicare, the only alternative for teaching hospitals is to shift the costs of GME programs to non-Medicare patients. The Secretary's mistake in both instances, and the reason her decision is arbitrary and capricious, is that she has failed to examine the actual record (*e.g.*, she ignored the 1985 cost study showing that the Hospital's additional GME costs were actually incurred in providing services to patients and she refused to look at the actual sources of support for those programs) and instead relied on unsupported "presumptions." The result of her approach is to require that reasonable costs actually incurred and *not* supported by the community were shifted to the Hospital's non-Medicare patients. Such a result is contrary to the meaning and purpose of the Medicare Act, and should not be allowed to stand.

CONCLUSION

For the foregoing reasons, Petitioner respectfully prays that the Court reverse the judgment of the Court of Appeals for the Third Circuit, and direct the Secretary to reimburse the Hospital for the reasonable costs incurred in support of its GME programs, in accordance with the findings of the PRRB.

Respectfully submitted,

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